INFORMED CONSENT FOR PARTICIPATION IN MONTANA MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION
www.dphhs.mt.gov/mfp/

Completion of this form is voluntary. Failure to complete it will mean that the individual cannot participate in the rebalancing demonstration.

Last Name_____ First Name: _____ Social Security Number_____

I HAVE BEEN INFORMED THAT:

- The Money Follows the Person (MFP) Demonstration is sponsored by the federal Centers for Medicare and Medicaid (CMS). The demonstration will support states to rebalance their long-term support system, transition individuals from institutions, and improve the long-term care system overall.
- CMS has awarded a demonstration grant to the Montana Department of Public Health & Human Services (DPHHS) to operate the MFP program in Montana.
- CMS has contracted with Mathematica Policy Research to evaluate the MFP program nationwide. Certain information about MFP program participants will be shared with CMS and with Mathematica Policy Research in order to meet the statutory requirement to evaluate the MFP program.
- My participation in the MFP program is completely voluntary.
- My refusal to participate in the MFP program will not affect my eligibility for Medicaid or home and community-based services.

BENEFITS OF THE DEMONSTRATION

Potential benefits from my participation in the MFP program include the following:

- I will be offered services under the MFP program to enable me to transition from the institution in which I live to a home, apartment or small group setting in the community. MFP program services will continue for one year but waiver or State Plan services will continue as long as I continue to meet the eligibility requirements for those programs.

PARTICIPATION IN RESEARCH

- Information about my participation in the MFP program will be provided to CMS and to Mathematica Policy Research, the evaluation contractor authorized by CMS.
- I may be asked to respond to surveys, participate in visits to my home, or otherwise communicate with the evaluation contractor for the MFP program.

CONFIDENTIALITY

I have been informed that the information provided by DPHHS to CMS and the evaluation contractor is confidential and will be protected under the Health Insurance Portability and Accountability Act (HIPAA).

WITHDRAWAL FROM THE PROJECT

- My participation in the MFP program is entirely voluntary. If I enroll in the MFP program, I may withdraw at any time by completing a withdrawal form. I can get the withdrawal form from my transition coordinator or care manager or from the MFP Project Director.
- I can withdraw from the MFP program and continue to receive waiver or State Plan services as long as I continue to meet the eligibility requirements for those programs.

COMPLAINTS

I understand that if I have any complaints or concerns about my participation in the MFP program I can contact the MFP Project Director, Senior & Long Term Care Division, DPHHS, 2030 11th Avenue, Helena, MT 59604-4210. Telephone: 406-444-7782. Email: trclark@mt.gov

I also understand that I have certain rights to file a grievance or appeal a decision as a Medicaid waiver participant. The transition coordinator has provided me with information regarding my rights as a Medicaid waiver participant and has provided me with information regarding the process to file a grievance or appeal.

CONSENT

My transition coordinator explained to me my rights and responsibilities under the MFP program. I understand that I will be given a signed copy of this consent form to keep.

By signing this Informed Consent, I am agreeing to participate in the MFP program and to accept all conditions for participation.

_____ _____
SIGNATURE – Participant Date Signed

_____ _____
Address (Street, City, State, Zip Code) Telephone Number

_____ _____
SIGNATURE – Legal Guardian (if applicable) Date Signed

_____ _____
Address (Street, City, State, Zip Code) Telephone Number

TRANSITION COORDINATOR ACKNOWLEDGEMENT

I have read the informed consent materials to the applicant, and I believe that he/she (or the guardian, if signed) understands the materials.

_____ _____
SIGNATURE – Transition Coordinator Date Signed

_____ _____
Name – Agency Agency Telephone Number